Durk V. Irwin, D.M.D. ORTHODONTIST
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Vancouver ORTHODONTIC Specialists

VANCOUVER
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Vancouver, WA 98685

BRACES FOR CHILDREN & ADULTS

Website www.vancortho.com
Email contact@vancortho.com

WHAT ARE THE MAIN CONCERNS THAT YOU WOULD LIKE ORTHODONTICS TO ACCOMPLISH?

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Have you ever been evaluated or had orthodontic treatment before? ☐ Yes ☐ No
Have there been any injuries to the face, mouth, teeth or chin? ☐ Yes ☐ No
List any musical instruments played: ______________________________

Have adenoids or tonsils been removed? ☐ Yes ☐ No
Have you been informed of any missing or extra permanent teeth? ☐ Yes ☐ No
Have you ever had any pain/tenderness in your jaw joint? (TMJ/TMD) ☐ Yes ☐ No
Do you brush your teeth daily? ☐ Yes ☐ No
Do you floss your teeth daily? ☐ Yes ☐ No
Do you bleach your teeth? ☐ Yes ☐ No
Are you currently under the care of a physician? ☐ Yes ☐ No
Physician: ______________________________
Phone Number: ______________ Date of last visit: ______________
Please describe you/your childs current physical health: ☐ Good ☐ Fair ☐ Poor
Please list all medications currently being taken ______________________________
____

Please list any food/drug allergies: ______________________________
____

HAVE YOU EVER HAD ANY OF THE FOLLOWING MEDICAL PROBLEMS?

Y N Abrnormal Bleeding
Y N Anemia
Y N Artificial Bones/Joints/Valves
Y N Asthma/Arthritis
Y N Blood Transfusion
Y N Cancer/Chemotherapy
Y N Emphysema
Y N Epilepsy/Seizures/Fainting
Y N Fever Blisters/Herpes
Y N Clenching/Grinding Teeth
Y N Congentital Heart Defect
Y N Convulsions/Epilepsy
Y N Diabetes
Y N Difficulty Breathing
Y N Drug/Alchohol Abuse
Y N Mitral Valve Prolapse
Y N Mouth Breather
Y N Nail Biting
Y N Glaucoma
YN Handicaps/Disabilities
Y N Hearing Impairment
Y N Heart Attack/Stroke
Y N Heart Murmur
Y N Heart Surger/Pacemaker
Y N Hemophilia
Y N Hepatitus
Y N High/Low Blood Pressure
Y N HIV/AUDS
Y N Hospitalized for any reason
Y N Kidney/Liver Problems
Y N Lip Sucking/Biting
Y N Psychiatric Problems
Y N Radiation Treatment
Y N Rheumatic/Scarlet Fever
Y N Severe/Frequent Headaches
Y N Shingles
Y N Sinus Problems
Y N Speech Problems
Y N Thumb/Finger Sucking
Y N Tongue Thrust
Y N Tuberculosis (TB)
Y N Ulcers/Colitis
Y N Venereal Disease

PLEASE LIST ANY OTHER MEDICAL PROBLEMS THAT YOU HAVE HAD: ______________________________
____
____

NEIGHBOR OR RELATIVE NOT LIVING WITH YOU

Name: ______________________________
Phone Number: ______________________________
Address: ______________________________
____

I understand that the information that I have given is correct to the best of my knowledge. I authorize the sharing of this information with my medical and/or dental provider(s).

I authorize the dental staff to perform the necessary dental services needed.

I give my permission for any photographs, x-rays, or study models to be used for displays at scientific meetings, presentations and publications of a scientific nature or for study group purposes to further the art and science of orthodontics.

____
Signature of Patient/Signature of Parent or Guardian Date

OFFICE USE ONLY

I verbally reviewed the medical/dental information above with the patient or guardian and patient named healthy.

Doctor's Comments: ______________________ Initials: __________ Date: __________
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